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ABSTRACT

Health communication, gerontology/geriatrics, and the interdisciplinary team approach to health care are considered together in this paper as a critical field for communication research. The first section of the paper offers a definition of interdisciplinary health care teams, then reviews their goals, composition, history and training. The second section explains how the team approach is applicable to geriatrics, while the third section reviews the literature evaluating interdisciplinary teams, listing both positive and negative findings, of which the most significant is the need for better team communication. The fourth section raises issues for further research and evaluation by health care and communications professionals working together. (FL)

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HEALTH TEAM LITERATURE: A REVIEW AND APPLICATION WITH IMPLICATIONS FOR COMMUNICATION RESEARCH

by
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The original version of this paper drew health communication, gerontology/geriatrics and the interdisciplinary team approach to health care together as a critical field for communication research.* This paper presents that case in an abbreviated form by:

1) Reviewing the nature of health care teams,
2) Clearly showing the natural application of the team approach to geriatrics, and, finally,
3) Raising issues about the evaluation and research of health care teams.

This approach allows us to take a broad concept such as the interdisciplinary health team and apply it to a specific area of study which is rapidly gaining attention (Note 1). The approach may similarly be applied in other areas of health care.

Evaluation and research issues which are raised are directed toward team care in general. The entire original list of references is included in this paper.

I. THE INTERDISCIPLINARY HEALTH CARE TEAM: A REVIEW

A review of the definition and goals, composition, history and training of health care teams clearly reveals their wholistic approach to patient care.

Definition and Goals

Interdisciplinary health teams have been defined by various authors. The Second National Institute on Interdisciplinary Health Education and Care defined the team as:

> A transitory social system, consisting of a number of persons working together for a defined and mutually accepted goal and according to a mutually accepted program in which each member understands and accepts his/her health care functional contribution to that goal. When used in the health care system, the team has as its goal the satisfaction of specific needs of an individual patient, a family, or a whole com-

* Paper available upon request

munity (Dowling, 1977, p.8).

Beckhard (1974, p.4) says "a team exists when a task or tasks require the interdependence of a group of people with different technical capabilities." Kindig (1975, p.100) describes a team as "a group of individuals who must work together collaboratively and interdependently to accomplish their work tasks at all, or well, or efficiently." Kane (1975a, p.34) defines teams as collections of unique individuals in dynamic interaction and adds that the team is a group with a purpose (pp.3,5). That purpose is improved delivery of complex care (Rubin, 1977, p.68) through coordination of the efforts of various disciplines toward the satisfaction of specific patient needs (Mather, 1977, p.27). "Teamness" is synergy, i.e., "the result of the team is more than a mere addition of the sum of its parts" (Thornton,1976,p.3).

Generally, the literature stipulates that a team consists of from two to twelve professionals and semi-professionals with differentiated expertise who work together to provide multiple services needed by a patient. Together the team can provide more efficient and effective care than each member can provide separately. The health care team, then, is an alternative to the traditional doctor-patient model of health care. (See also: Luszki, 1958, p.10; Bottom, 1980; Plovnick, 1976, 1978; Johnson, 1981; Edinberg, 1978; Kane, 1975b,1980.)

Many writers view teams as a necessity if adequate health care is to be given in light of the complexity of contemporary health needs, specialization, and technology (Rubin, 1977, p.57; Mather, p.24; Lowe and Herranen, 1978, p.323). Giorgi (1978), a physician, says:

> Medical care is only a small part of what people, families, and communities need in terms of care. The services we render must be preventive and restorative, as well as curative. They must address psychosocial as well as biological needs. They must be comprehensive, coordinated and continuing as well as available, accessible and acceptable (p.73).

The team goal is to utilize the skills of several health professionals in order to provide that comprehensive care for the patient.

Team Composition

In order to provide this comprehensive care, interdisciplinary

teams may be comprised of members with different professional training: social work, nursing, medicine, psychology, psychiatry, occupational and/or physical therapy, speech pathology, nutrition, pharmacology, dentistry, podiatry, health education, gerontology and communication (Edinberg, 1978, p.204; Bottom, p.110, Mather, p.27). The primary care team ordinarily consists of physician, nurse, social worker and a medical technologist (Thornton, p.2). Kane (1975) found 162 different combinations of professionals in a sample of 229 journal articles on teams (p.61).

Team Size

Kane's (1975a, p.54) research into the ideal size of teams concludes that teams should not be very large. Luszki (1958) suggests that involving fewer disciplines may facilitate the expression and resolution of conflicting views on the team. Theler (1954) says that the group should be large enough to include all individuals with relevant skill for problem-solving but no larger.

History of Health Care Teams

The history of team health care illustrates growing utilization of the approach. Collaboration of health-related disciplines is not new, of course. It has been practiced for a long time with mental health patients, rehabilitation of the handicapped, special surgical procedures, child guidance, cancer treatment and other long-term illnesses (e.g., epilepsy), burns and pain control (Blumberg, 1980, p.17; Vachon, 1978; Arntson & Montgomery, 1980; Mather, p.23; Dowling, p.9; Thornton, p.4; Resnick, 1980; Kane, 1975a, p.17).

Kane (1980, p.138) points out that with the resurgence of family medicine and the demand for an approach to the "whole person," the notion of the team has been "rediscovered" in the past decade (Note 2). The present enthusiasm for interdisciplinary health teams grew chiefly out of two pioneering primary care programs that were developed initially to provide integrated patient care (Mather; Thornton, 1976,1977; Cherkasky, 1949; Kindig, 1975).

The first of these programs was at Montefiore Hospital in the Bronx. In the 1940's, under Martin Cherkasky, a team comprised of a physician, nurse and social worker organized a hospital outreach program. The Family

Health Maintenance Demonstration Program was established shortly thereafter by George Silver in conjunction with the Montefiore Medical Group. It was formed as a demonstration model for delivering comprehensive family medical services with an "emphasis on combining prevention and treatment of both physical and emotional disorders" (Mather, p23). The model was started at a time when medical specialization had begun. There was a growing recognition that general practitioners might not be able to handle all of a patient's problems single-handedly.

Following positive evaluation of the Montefiore project, Silver and Wise opened a second model program, the (now) Dr. Martin Luther King, Jr. Neighborhood Health Center, to provide family health services to a low income population in the South Bronx (Thornton, p.5). By 1969, eight primary health care teams, consisting of internists, pediatricians, nurse practitioners and family health workers were caring for approximately 28,000 patients a year (Mather, p.24). These two centers still serve as focal points for research on teams in the United States.

Kindig (p.98) reports Altman's 1974 paper in which he argues that the "critical incident" in the popularization of the health team concept was the mention of the team approach in the OEO Neighborhood Health Center Guidelines in 1966.

Supporters of the team concept view it as a viable alternative to traditional medicine - especially in public health centers and university-related facilities. Thornton (1977, p.5) cites examples of such programs at Columbia Point, a student study in Appalachia, The Universities of Nevada, Kentucky, Wisconsin and Yale. Team training is popular in continuing education and staff development and often provides an actual team experience (Kane,1980, p.144; Mountain States Corporation, 1979). Teams are now used more frequently in general practice because they provide additional resources and support of patient and practitioner (Madison,1974; Crammond, 1969).

Into its fourth decade, the team approach has spread from the Bronx to many areas of the nation and is found in a full range of health care settings - from general practice to hospitals and senior residences to large cities (Master, 1980). As the popularity of teams has increased, more attention has been focused on the need to provide training in the special skills required of health care providers for effective team care.

Team Education and Training

Most team education and training has centered around small group and/or organizational development, i.e., issues and skills related to leadership, role negotiation, goal-setting, problem-solving, conflict and conflict resolution, team development and normative behavior (Bottom, 1980; Crocket,1970; Edinberg,1978; Eichorn,1974; Johnson,1981; Kane, 1975, 1980; Lowe and Herranen,1978; Rubin et al.,1975,1977). Rubin et al., have marketed a Health Team Development packet. Following a self-instructional method, team members assess their own perceptions and deal with the issues of roles, goals, procedures and interpersonal trust and support. Resolution of these issues leads to the "disappearance of interpersonal tensions and personality clashes." From this perspective, team development is seen as a "planned maintenance activity aimed at preventing major problems from occuring" (Rubin, Fry, Plovnick & Stearns, 1977, p.69).

Many see the team experience as a re-education process oriented toward integrating practitioners who have traditionally remained separate. Mather (pp.25,27) stresses the importance of sensitivity to each others' expertise and procedures. He sees the team as the place to begin that re-education. Szasz (1969) sees the team as a common denominator for better interdisciplinary relationships. Szasz underscores the re-socialization of physicians who have previously been encouraged to compete rather than to cooperate.

On the other hand, Kane & Kane (1969) found that sixty-seven percent of the physicians they surveyed felt that doctors could solve health problems alone. Only 16 percent felt that new approaches were needed. Thornton (1976, p.57) reported that medical students in a team education course argued that clients wanted a private relationship with the doctor. They were instructed to check it out with the patients and "found unanimously that patients were quite willing to have other team members present at physical examinations, history-taking, etc." In fact, "in every instance when the patient was given the clear choice of a private physician-client relationship or a choice of relationships with the other members of the team, they took the latter alternative" (p.101). Thornton added that shattering this myth was dissonance-provoking for medical students.

We might conclude that physicians have a difficult time relinquishing their traditional role as chief providers of patient care and accepting the team concept. The team emphasizes the viability of the opinions and care of all practitioners. Both Stein (1967, p.210) and Thornton (1976, p.55) report traditional doctor-nurse indirect communication and the adverse effects of concern over egos rather than efficient care. Training in team effectiveness must address role relationships.

Bates (1970) observes that some role-blurring is beneficial as an wholistic approach to patient care and is practiced by clinical specialists or physicians assistants (p.201). She believes that the doctor-nurse team is "able to identify and meet a wider spectrum of patient needs especially appropriate for complex or long-term problems." Bates notes, however, the problem of physicians feeling that their responsibility and/or authority is being usurped(p.202).

From the previous discussion, it is apparent that the concept of interdisciplinary interaction and cooperation ought to be introduced early in the education process of health care providers (Thornton,1977,p.15; Lewis, 1965; Baldwin, 1974; Edinberg, 1978).

Beckhard (1974) reviews the issues surrounding team training in delivery versus educational settings and in both the establishment of new teams and the maintenance of practicing teams.

Despite the potential pitfalls of maintaining some of the traditional professional roles and attempting to determine the best approach to team training, teams appear to be fairly well established as an alternative to the traditional treatment model. Bottom (1980, p.106) argues that "it is no longer a question of whether the teams should be used, for they are a 'given' and are here to stay for many years to come."

The wholistic nature of the health care team makes it perfectly applicable to a specific area of medicine - geriatrics - the study of disease in the elderly.

II. APPLICATION OF TEAMS TO GERIATRICS

While primary care teams are applied generally in medical practice, they seem especially well-suited for dealing with the complex chronic biopsychosocial problems presented by older adults where an integrated approach to services and care is essential (Bottom, p.110; Quinn,1979,p.53; Edinberg, p.205; Dingwall, 1980, p.117; Master, et al.,1980, p.1435;

Kane, 1980, p.148). Although aging is not a disease, there are biological, physiological, anatomical, psychological and sociological changes which accompany the passage of time (Adelman, 1982, pp.95-96; Botwinick, 1978; Woodruff & Birren, 1975). The longer we live, the more probable it is that we will experience such changes.

Aging and Change

Most gerontologists and geriatricians agree that older people (especially age seventy and over) will develop chronic and multiple illnesses (Primary Care Concepts, 1981, p.371; Weg,1975, p.232). While longitudinal studies on the physiology of aging are sparse, the studies by Shock (1962, 1968), Birren et al. (1963-1971), and the Duke Center (Palmore, 1970,1974) reveal that older adults are twice as likely to be physically disabled and require hospitalization as younger adults and to be especially vulnerable to disease. A survey of inpatients revealed an average of nine problems per visit for older patients (Primary Care, p.400).

Health care costs for this eleven percent of the population in 1976 were over forty billion dollars, roughly thirty percent of the nation's personal health care budget. This eleven percent of the population consumes twenty-five percent of the drugs and medications annually prescribed (Levy & Glanz,1981, p.61).

Major illnesses associated with aging include coronary heart disease, cerebral accident (stroke), and cancer. In addition, high blood pressure, arthritis, genito-urinary problems, diabetes, sensory loss (hearing, sight, taste, touch and smell), loss of neuromuscular coordination and decreasing ability to recover from physical and emotional stress may plague older adults. Many of these problems severely reduce ability to function fully. The older adult often functions with more than one of these problems (Primary Care, p.372). Eisdorfer, (p.258) concludes that:

> Eternal life, or a universal pattern of death occuring suddenly and peacefully after a long, happy and healthy existence entirely free from disease, disability, dysfunction, and pain are wonderful hopes, but not realistic prospects.

Clearly, as our population ages, health care specialists must be prepared to care for a growing number of sick, elderly persons.

In addition to the problems of poor health, older adults face many other changes which may affect the quality of their lives. Bettinghaus

and Bettinghaus (1976,pp.129-154) present a review of physiological and environmental changes and their related social-psychological problems which potentially confront the aging adult.

Briefly, changes in hearing, vision, mobility and living arrangements can be devastating for the aged. Coupled with ill health, loss of spouse or friends through death, loss of job and/or family roles, they can crea e isolation and loneliness. Apparently, they can even trigger death (Bloom,1971; Travis,1966; Botwinick,1978, pp.142-153; Lawton,1970; Ingram & Barry,1977; Kasl,1972; Blenker,1967; Costello & Tanaka, 1961; Lieberman,1961; Novick,1967 all discuss such trauma).

Bettinghaus and Bettinghaus also examined disrupted communication patterns of the elderly in relation to cognitive balance theory, dependency, locus of control and attitudes toward the aged. Their examination suggests that older persons might reject or repress confusing or inconsistent information rather than challenge it. In the instance of institutionalization, for example, one might find false symptoms of senility exhibited which protect the vulnerability of the older adult who is unable or unwilling to interact in a strange, new, undesired environment.

Further, Bettinghaus speculates that when others, however well-intentioned, speak <u>for</u> elders, premature dependency may begin. Very few older adults need to be fully dependent, and those who do <u>not</u> resent being treated like children. Roles may shift and require re-definition as elders' needs increase, but roles do not reverse (Hirschfield & Dennis,1979).

Recognition of the complex changes which may face the older adult and traditional negative attitudes toward them has led to attempts to provide practitioners with guidelines and training programs for facilitating interaction (see Blazer,1978; Fritz,et al.: Burnside,1976, p.885; Bloom,1971; Bottom,1980; Duke-Watts Family Medicine, p.14).

Eisdorfer maintains that extended contact with older adults will help eliminate a "psychophobia in medicine, a rejection and fear of dealing with interpersonal and cognitive changes in people" (p.257). As Cicero pointed out in his essay "On Old Age," it is not old age that is at fault but rather our attitude toward it!

<u>Aging And Health Care</u>

While aging seems depressingly predictive of a complexity of problems, gerontological literature helps us draw more optimistic conclusions. Older

people vary widely in personality, behavior and socio-economic background and in health. Health and social needs, then, differ. We know that many older adults accommodate various levels of illness into normal functioning.

Brotman (1974) found that "approximately eighty-six percent of the people over age 65 remain in their communities and demonstrate more than adequate coping behavior in meeting the challenge of everyday living." "Greater numbers of older people are living longer, are in better health, better educated, and are determined to remain involved with living" (Weg, 1975,p.253; Newgarten, 1975,p.90). Aging in the twentieth century appears to be a process of adaptation.

Geriatric medicine, now recognized as an essential component of general practice, is concerned with the clinical, preventive, remedial and social aspects of illness in the elderly. Physicians seem to be recognizing that the goal of health care for the chronically ill older adult is an overall improved quality of existence - the maintenance of a dignified and useful lifestyle. Often this may involve caring and comforting more than curing (Primary Care, pp.383-384). It is interesting that it has only taken two thousand years to follow Cirero's advice from 80 B.C.:

> The competent physician, before he attempts to give medicine to his patient, makes himself acquainted not only with the disease which he wishes to cure, but also with the habits and constitution of the sick man.

Practitioners treating older adults, thus, are finding it imperative to become sensitive to the specific needs of patients in their own environment, i.e., the biopsychosocial approach to care of the elderly. Often this requires the skills of many health professionals.

Geriatrics and The Team Approach

Most of the literature on teams does not specifically discuss the geriatric team though there is evidence that the geriatric team is increasingly gaining attention. Kane (1975,p.43) notes the importance of dealing with the chronically ill by utilizing teams. Brody, Cole and Moss (1973) advocate geriatric interprofessional teamwork. Master (p.1435) points out the need for a variety of caregivers "particularly for the homebound and nursing-home groups."

Recently developed geriatric teams follow in the footsteps of the

Triage Project in Connecticut which is a model for coordinated health, social, life-support and follow-up services for 3,000 elderly clients. Triage provides "humane and cost-effective long-term care in the person's home when possible, preventing inappropriate institutionalization" (Quinn, 1979, p.50). The Master (1980) project also modeled integration of multiple services in Boston.

The Veteran's Administration has begun a Geriatric Evaluation Unit in Sepulveda, California to train interdisciplinary teams. Temple University's Department of Community Health and Family Practice operates a team education module (MacBride, 1979). The University of Nevada, Reno (Edinberg, et al.,1978) has also instituted an interdisciplinary instructional program in geriatrics. Like the Temple program, it was funded by a grant from the Department of Health, Education and Welfare. In 1979, the University of Kansas Gerontology Center and Kansas State University's Center for Aging, through a three-year grant from the Administration on Aging, developed a team practicum placement in gerontology (Patterson & Jess, 1981).

It is important to note that these geriatric teams largely function to aid the 86 percent of "well" elder adults in maintaining as normal an existence as possible outside of institutions in the face of multiple and/or chronic illness/es. Mather (p.25) sees this function as the delivery of primary care in non-institutional settings, with the patient included in the caring and curing.

Potentially, the caregiver benefits from such interaction through an increased understanding of aging, older patients in general, and their own attitudes toward aging (Benson,1979, p.579; Edinberg; Blazer,1978; Osterkamp, Crockett & Press, 1981,p.2; Cantrell).

The geriatric team members are concerned with the interconnectedness of social, physical and psychological aspects of patient problems. The team focuses on identifying patient's capabilities and minimizing limitations.

An interdisciplinary geriatric team effort, then, is based on an holistic approach to health care and may be applied in any of the variety of health settings in which the elderly are found (Weiner,1978). The team may operate in the home (Oginbene,1981), at ambulatory sites, in hospital extended-care facilities (Master, p.1438), primary care offices, neighborhood clinics, senior housing complexes, wholistic health centers and hospices - which provide care for the terminally ill and their families

(Stoddard,1978).

We can see that teams appear to be a viable method for dealing not only with a specific area of medicine, but can also be used in any setting where the skills of several professionals are required. The issue, then, is not whether teams should exist, but whether they do, in fact, fulfill their purpose -- better patient care.

III. EVALUATION OF THE INTERDISCIPLINARY TEAM

In the face of widespread utilization of teams, an alarmingly small amount of empirical data exists which substantiates their effectiveness. Kane (1980,pp.141,146-7) maintains that evaluation of care given by health teams is one of the weakest aspects of research in that team evaluation is "fragmentary or non-existent" (p.141). Kane warns that though team work has been "rediscovered, affirmed, defined, conceptualized, justified, taught, and funded," it has been only "occasionally studied" (p.138).

Kane's (1975) study revealed that more than half of the 229 team-related articles surveyed made no mention of team self-assessment. Teams which did attempt evaluation generally related success to achieving goals (p.60). The survey found that teams were not compared to other forms of health care, e.g., independent professionals or coordinators. Only 9 percent of the teams surveyed assessed team member satisfaction (1980,p.141).

Master (p.1439) points out that "a particularly crucial" issue not addressed in their study (and one very difficult to measure) relates to the quality of care provided by their continuity system.

Perhaps this lack of evaluation is due to the recency of the rediscovery of teams. A second possibility is that the evaluation of a team is too complex an undertaking. Master (p.1439) says that "for elderly and chronically ill populations, quality of care is difficult to define and moreso to measure."

Kane (1975) speculates that evaluation may not have been attempted for two reasons: 1) goals were clearly set in only 23 percent of the cases and thus assessment of achieving goals was impossible, and 2) self-evaluation might tend to undermine the "camaraderie" of the team (p.61).

Kane emphasizes the fact that in some instances it has been the belief in teamwork itself - an ideology, a faith - which has characterized the team rather than a careful analysis of goal achievement or the relationship of process to outcome (p.139, 141). Dingwall (1980,p.113) dis-

cusses the word "team" as a "linguistic tool," a rhetorical device, which is used conceptually/metaphorically more than it is actually practiced. Kane (1975a, p.2) adds that the "metaphor of a team" masks the full range and complexity possible in interdisciplinary interaction and cooperation. It makes it easier to avoid the elements of effective teamwork. She argues that a stronger faith in evaluation might help to assure the value of teamwork and justify the emotional climate surrounding it.

Studies which have attempted to evaluate team effectiveness began with a 8-year follow-up assessment of the Montefiore Family Health Maintenance Demonstration project in the Bronx. This study indicated that both patients and professionals were satisfied with the team model and that the health of the families improved along with their housing and nutrition (Beloff and Karper,1972).

Thornton's dissertation (1976,p.48) on student health teams at the University of Nevada revealed that families:

> appreciated the examination and explanation time spent on them. Almost all of the families were frustrated in their attempts to deal with their family physicians. The students were seldom, if ever, accused of the same slight. One woman cried when she told the nurse who had given her a physical examination that no one had ever spent so much time answering questions and teaching her about her body.

The Sepulveda Demonstration project evaluated team education in geriatrics. Giorgi reports "improvement in services and lowered overall costs through meaningful coordination"(1980,p.78). Master (p.1438) found that:

> Primary care teams that provide care in all necessary settings and are run through neighborhood health centers, certified home-care programs, and nursing home-care programs appear to be effective both in providing needed care and in reducing inappropriate and expensive reliance of these high-risk groups on teaching hospitals, primarily by reducing both the length of stay of hospitalization and, for at least some patients, the incidence of hospitalization as well.

Friedson (1970) found that patients rated teams high in both personal care and technical competency.

Rubin (1977,pp.64-65) found that in the 13 teams which field-tested their Development Program (and in an additional 40 teams which used the program), 54 percent of the teams reported experiencing 1) "a sense of direction, optimism and forward movement" by acquiring the ability to agree on goals and priorities and 2) a better sense of how to run a more productive meeting. 69 percent of the teams reported an opening of lines of communication due to sessions in role negotiation and definition. 85 percent experienced improved case conferences and 67 percent perceived improved patient care (p.68). This, of course, is a small sample reflecting self reports rather than observation, but it does indicate the importance of communication about organization which is the crux of the program.

Much of the literature which seeks to provide some assessment of geriatric teams centers on positive and negative aspects of the team (Bottom; Edinberg; Ruesch, 1956,p.111; Thornton, 1977; Kane, 1975,p.12 and 1980,p.149; Rubin, Fry, Plovnick & Stearn, 1977,p.68). Possible positive aspects of the team include:

a) increased understanding of patient problems due to the breadth and longevity of services,

b) coordinated services, i.e., systematic integration and lack of duplication of services - better management of time, skills, money - efficiency,

c) access to other professions and alternative treatment modalities and solutions through increased and improved communication of other's skills,

d) support of colleagues in patient care which reduces stress for any one caregiver,

e) rotation of leadership/responsibility - determined by patient needs,

f) more accessible care for the patient,

g) knowledge of aging, team process, others' skills through multiple viewpoints, and

h) more conscious efforts to follow through on cases as members work together.

Some of the negative aspects which may arise include:

a) too much diffusion of responsibility for the patient resulting in a tendency to avoid individual responsibility and thus provide less than maximum care,

b) a lessening of the possibility of a close relationship between patient and single practitioner,

c) time-consuming protocol and meetings which may be expensive and possibly create over-absorption with group process,

d) poor communication among team members - sometimes caused by domination of the team by one individual, or by having to give up traditional control,

e) dissatisfaction with the team experience due to poor communication skills and leadership,

f) contradictory or unclear roles, goals/objectives, i.e., who is going to do what and who makes the decision, and, possibly,

g) intradisciplinary jargon which is dysfunctional for understanding and cooperation, especially with para-professionals.

Many of these items may, of course, apply to any health team and they clearly suggest that effective communication is vital to the functioning of the team. Yet Kane (1975a, pp.30-31) reported that studies on health care teams point to numerous examples of poor communication among members of different professions. The consequences of poor communication are conflict and role confusion, she argues, and proposes studies which evaluate team interaction. Such studies would yield valuable data for the education, training and operation of teams.

Thornton (1977) also reported the "overwhelming need" cited by health team scholars for better team communication (pp.16-17). She says:

> A summary of prior research indicates, then, that communication is considered to be a prime focus in the study of the health care team and that is is only through study of communication patterns that the researcher will find the necessary information as to how the team negotiates roles, makes decisions and delivers effective client care.

Thus, communication and health care professionals are faced with a clear mandate to unite to provide useful research to aid team functioning.

IV. ISSUES FOR RESEARCH AND EVALUATION

Health team literature repeatedly ends with a plea for more research in this area. Certainly, communication scholars ought to be

able to aid in the task of finding answers to questions of how the team works, to what effect, and how communication facilitates (or hinders) the process. While we may intuitively feel the value of the team approach, basic issues of how to approach team evaluation or research on effectiveness remain unresolved, largely due to their complexity.

The issue is not whether to utilize the team. "The Team" is in use in many settings and is mandatory whenever patient care must be provided by more than one caregiver. The issue, then, is how to best coordinate efforts to insure better patient care - the generally stated team goal (or desired outcome).

Problems arise, however, when we attempt to provide sweeping solutions for facilitating teamwork, when we suggest a particular form of team research (or evaluation), or when we use terminology as if teams universally apply those terms.

Because teams operate in myriad situations and with as many structures, there are few totally generalizable guidelines. We must address, as Beckhard (1974) cautions, a variety of teams in both delivery and educational settings. Further, we must recognize needs of both established and newly-formed teams as well as how to approach teams which are faltering and teams which are functioning well. Different approaches to training and research are required which will meet the needs of particular teams in particular situations. This variation makes team evaluation difficult.

In addition, there is the issue of who should evaluate or research the team. Should this be an internal analysis (with problems of validity) or should outside investigators analyze the team?

Problems may arise if administration has ordered the evaluation of delivery teams and members perceive a necessity to justify the team in terms of time (team meeting time, numbers of patients, patient waiting time) and/or money, i.e., efficiency. Members may feel threatened by such evaluation. The fear of negative findings may cause them to react overly positive which may not render a realistic evaluation. Where teams are not seen as efficient by administration, team requests for evaluation may be denied thus preventing any possibility of improvement. Evaluation of educational teams is part of that experience and thus are generally not as threatening as it is in a delivery setting.

Another difficulty centers on the professionalism of team members who are trained to decide on and do whatever tasks are before them. Eval-

uation, then, can initially be seen as questioning or doubting decisions. Uncertainty could be dysfunctional if viewed in this manner. Evaluation may also be perceived negatively by practitioners who are sold on the team concept and see any evaluation as an attempt to undermine it.

Practically, of course, when we research health issues we are into the realm of patient's rights and issues of privacy if we hope to include the patient in the study.

Finally, we face the issue of empirical studies,e.g., large sample surveys, which may not reveal the richness of human interaction versus ethnomethodological studies which are largely non-generalizable.

A major problem in researching teams lies with the assumption that terminology either across or within teams is universally applied.

Generally, team goals sound alike: coordination of effort to achieve better patient care. The problem is with different perceptions of meaning which teams and members of those teams may have. What does coordination mean? Does it mean that the team does not duplicate effort or fragment care? How do we measure that? Can we diagram a network of coordination? And if we determine that the team is coordinated, how do we measure better (or quality) patient care? What outcomes are we looking for? What is "better?" Is it efficiency (e.g., time, money - internal payoffs) or effectiveness (e.g., patient satisfaction - with care or caring or education, compliance) or a combination of the two? To whom are the outcomes directed? Who gets what? If the goal is better (or quality) care, who determines that it's better? Answers to these questions will determine how we go about evaluating whether or not the team achieved its purpose.

It is clear that there are problems with researching health teams. It should also be clear that communication scholars have an exciting field to pursue.

Research on teams should range from intrapersonal (perception of roles, expectations, satisfaction of each team member) to interpersonal (patient/practitioner, practitioner/practitioner) to small group (team interaction) to mass (public information/education, surveys) communication. Certainly the rhetorical aspects of the team would be an interesting study - including speaking skills, language choices and the idea of the team as a metaphor. Hart (1980) and Carlson's (1978) work on rhetorical sensitivity might be applied to find profiles of team member's communication predispositions.

Two areas seem especially applicable to teams, of course: interpersonal and small group communication.

Interpersonally, team members must work with each other and with patients. Both have expectations and vulnerabilities and perceptions of care and caring. The issues of vulnerability and sensitivity to patient cues regarding information are key for team members dealing with serious or terminal illness. Signals must be clear here.

Kindig (pp.821-2) underscores the need for interpersonal skills such as listening and offering support. Kane (1975, p.15) points out the benefits of professionals being tuned in to each other's skills and feelings. Patients often express a desire for more information than they receive (Waitzkin & Stoeckle, 1972).

It would appear vital to match perspectives of practitioners and patients. Laing (1966) could be modified to simply match not only direct but also metaperspectives in order to check out interpersonal perceptions. This investigator is currently working on just such an instrument to measure physician/patient perspectives.

Similarly, this method could be used to measure patient's perceptions of the team to determine whether it is necessary or beneficial for the patient to know that a team is in operation. What impact might that knowledge have on patient satisfaction/health? Beckhard (1974,p.7) reported that "there is almost no reliable data that patients see a marked difference (in cure rate)." In fact, one might hypothesize that a group might not be perceived as satisfactorily as individual team members who do their jobs so well that the patient simply reports "good care." We need to update that information.

We need to know how the team impacts on a patient's health. We might administer pre and post questionnaires on expectations and outcomes for both team and patient.

The team as a group must be involved not only with tasks, but also with team building (Kent, 1974) as a part of team maintenance. Building and evaluating the roles and goals of the team together appears to be helpful (Plovnick, et al.,1978), but we need to go to the teams as they operate (not with shoulds and oughts - Waitzkin & Stoeckle) and ask them what is "working" and why they think so. What are the characteristics of a "good team?" How does this square with the patient's perception?

Looking at the content of team interaction is valuable. Phillips

(et al., 1979, p.4) argues that group research ought to analyze "what was said, by whom, with what effect." Videotapes of student teams in geriatric training at Temple University were most revealing in terms of roles, turntaking, power, leadership, and conflict.

We might well study the effects of sharpening group discussion skills regarding formation of questions of fact, value or policy for beginning, maintaining and changing group procedure. This may help focus evaluation and remove some of the threat.

Chiefly, research and evaluation must be pragmatically valuable for teams as well as advance theory. It ought to result in guidelines which will aid teams in setting goals and measuring outcomes. Somehow, the patient must be included in the data-gathering.

Perhaps large-scale surveys would help us determine a typology of teams which we could then study in depth. Certainly methods must be adaptable to specific situations and teams - as Phillips (p.4) cautions - the particular, not just the general case if they are to benefit each team where and when it is operating.

Clearly, the task has just begun!

NOTES

1) Growing popularity of the study of gerontology (the logic of aging) in the past quarter century is evidenced by the vast increases in publications, conferences and professional meetings addressing problems associated with aging. A bibliography of biomedical and social science research and applied professional aspects of aging between 1954 and 1974 lists nearly fifty thousand titles (Woodruff,1975,p.3). The First International Association of Gerontology meeting held in Belgium in 1950 hosted only 95 participants from 14 countries. In 1972, the International Congress of Gerontology held in the Soviet Union drew over 2,000 participants from 45 countries (Burnside,1976,p.4). Numerous national, state and regional agencies, organizations and centers operage across the nation.

It is not surprising that interest in gerontology has risen dramatically. Actuarial statistics from 1900 to 1980 reflect a large shift in the number and percentage of older adults in all developing countries. The population of persons aged sixty-five and older has increased several times more than the total population in this country. The percentage rate of older people increased from 4.1 in 1900 to 9.9 in 1970 to 11 percent in 1978 and is expected to reach 13 percent by the year 2000 and 18 percent by 2030! Presently, that 11 percent represents twenty-four million Americans over age sixty-five. One million of them are over eighty-five and there are thirteen thousand centenarians! If current trends continue, by the year 2000 elder citizens will number 32 million.

These demographics show that there has been and will continue to be a larger percentage of older adults in our society. The implications to be drawn from them are profound. We must identify and understand biological, psychological and social changes that come with advanced age so that we can be prepared to deal with them effectively. Eisdorfer (p.24) adds personal motivation when he says: "We have met the aging and they are us." (For demographic information see, especially, Cutler & Harootyan,1975; Harris & Cole, 1980,pp24-26; Benedict, 1981,pp.2-3; Smith, Bierman & Robinson, 1978,pp.23-25; Eisdorfer, 1981, p.256; Botwinick, 1978,pp.1-8.)

2) Tubesing (1977, p.1) says:

> Wholistic health care is based on the metaphysical affirmation of body, mind and spirit integrated in a whole, independent of and greater than the sum of its parts. In practice, wholistic care means actively searching with people all dimensions of their lives (physical, emotional, intellectual, spiritual, interpersonal) for causes and symptoms of disease, then creatively exploring these same aspects for treatment strategies to restore or maintain health.

The wholistic approach to health care, then, is interdisciplinary and employs physician, nurse, counselor and patient in exploring individual biopsychosocial needs (Westberg, 1979, p.3; Weeks & DeVries,1978).

Salmon and Berliner (1980, p.535) maintain that this 1970's movement is a "forthright rebellion against the philosophical and clinical orientation of scientific medicine" in the United States. They include "people engaged in self-care practices" attempting to "alter their health status through lifestyle adjustment" and "practitioners who offer a wide range of therapies outside the mainstream of modern medical practices" as participants in the movement.

Over two hundred wholistic centers operate across the country and range in approach from alternative therapies (Berkeley Holistic Health Center, 1978) to the Kellogg Foundation-funded Chicago Centers which combine conventional Western medicine with Christian counseling (Tubesing, 1976, 1979; Newport, 1981).

Wholistic health is a "wellness"/preventive approach to health care which challenges the traditional illness/interventive medical model (Rinzler, 1981; Levin, 1975) and emphasizes invdividual responsibility for health and longevity (Grossman, 1981; Brody, 1978; Peterson, Tubesing & Tubesing, 1976; Bloomfield & Kory, 1978; Time, 1978).

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